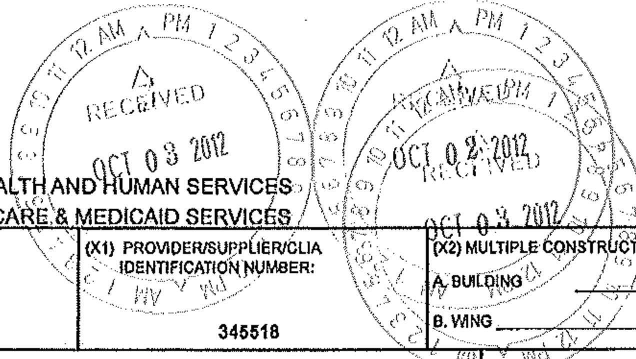

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING ______ B. WING ______	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL HAVEN VILLAGE	155 BLAKE BLVD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	F 156 **483.10(b)(1) Notice of rights, rules, services, charges:**	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156	**For residents affected/For residents having potential to be affected:** *LTC (Long Term Care) Survey Guidelines 483.10 (b)(1) were reviewed with SW (Social Worker) by DON (Director of Nursing) on 09-04-12. *Review of presentation board was completed on 08-31-12. All state agency information was displayed as required. In addition, resident handbooks that were in place in rooms were also evaluated on 08-31-12 and all noted to have correct information listed. *Executive Director evaluated the board on 08-31-12 and approved display. Prominent signs were also posted in front entrance of Inn and adjacent nursing station (500+600) to identify location of state contact information on 08-31-12. **Measures in place/monitoring solution:** *Any changes in advocacy listing requirements will be addressed by Executive Director in weekly leadership meeting. SW (social worker) will make changes as indicated. *DON (Director of Nursing) or other designated RN (clinical	9-20-12.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 9/21/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical	F 156	supervisor) will evaluate the presentation board for appropriate adjustments made to insure meeting regulation guidelines by dates indicated. Issues noted will be addressed with SW (Social worker) and Executive Director immediately. *Any concerns will also be addressed at the QA committee meetings and followed as indicated with any further recommendations. **483.10(b)(5)-(10):** **For residents affected/For residents having the potential to be affected:** *LTC (Long Term Care) survey Guidelines 483.10(b) (5)-(10) were reviewed with Business Office Manager by DON on 09-04-12. *Audit conducted of SNFABN (advanced Beneficiary Notice) for past 6 months. Audit was completed on 09-20-12 by Business Office Manager. All other notices issued at least two days in advance of denied benefits for Medicare skilled services. **Systemic changes/Monitoring solution:** *In addition to informal meetings, any changes in payor sources will be discussed in morning stand up meeting that Business office manager attends. Minute outline	

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F 156	Continued From page 2 or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility did not prominently display State Agency contact information as well as failed to provide a minimum two days notice for 1 of 3 residents (Resident #73) denied benefits for Medicare skilled services. The findings include: 1. On 8/27/12 at 6:15 pm, during the initial tour of the facility, a bulletin board was observed across from the 300/400 halls nursing station, containing information to contact state agency and advocacy groups. The bulletin board was near the activities area, which was a considerable distance from the front lobby where visitors entered the facility. There was an exit door near this nurse's station	F 156	revised as of 09-10-12. Business Office manager will submit notice timely as outlined in regulation manual as indicated. *Medical Records Director will review dates of all Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) issued, as indicated as benefit periods end, starting 09-10-12 and notify DON of any concerns. *Any concerns will be addressed immediately with Business Office Director and Executive Director. Concerns will also be forwarded to QA committee and followed as indicated.	

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F 156	Continued From page 3	F 156		

and activities room, however, no guests were observed to use this door throughout the survey.

In addition, there were no observed signs noted throughout the building, to identify the location of the state contact information.

On 8/28/12 at 10:10 am and 8/29/12 at 1:00 pm, the same observations were made.

On 8/30/12 at 1:45 pm, the Administrator was notified that the state contact/advocacy information was not placed in a prominent location. He shared that he would make the information more visible for all to review.

2. On 8/29/12 at 4:45 pm, a record review was conducted and revealed that Resident #73 was admitted to the facility on 2/4/12. On 3/29/12, the business office prepared a letter, Skilled Nursing Facility Advance Beneficiary Notice, which indicated that after 4/1/12, Resident #73 ' s daily therapy services would not be covered by Medicare since her condition had improved.

Attached to the Skilled Nursing Facility Advance Beneficiary Notice, was the Notice of Medicare Non-Coverage, dated 3/29/12 which conveyed that skilled nursing services would end on 3/31/12. A note on the form, read " Tried to contact RP (responsible party) prior to 4/3/12. "

On 4/3/12, the RP signed both of the forms, acknowledging receipt and understanding of the notices.

The Administrative Staff #4 was interviewed on 8/30/12 at 11:00 am. She indicated that she had

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F 156	Continued From page 4 been in her position since last October. She shared that she was aware that she should document all efforts of communicating the handling of liability notices for Medicare Non-Coverage and that normally she records actions taken in a notebook or on the chart, under the Admissions tab. She stated that she wasn ' t certain if she had recorded her efforts for Resident #73 however she did recall that she placed a call to the RP (not sure of the day) and told the nurses to inform the RP that he needed to sign a form in the business office, when he arrived at the facility for his customary daily visit. She shared that days went by and the RP did not make a visit. She learned later that he was out of town. The Administrative Staff #4 stated that after she placed a call to the RP she did not follow up and send him the notice by mail.	F 156		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the medication error rate was 5% or below by not following the doctor's orders and the manufacturer's specifications. There were five errors out of fifty one opportunities resulting to a 9.4 % error rate (Residents # 72, # 8 & # 58). The findings include:	F 332	**F332** **<u>483.25 Quality of Care-Free of medication error rate of 5% or more</u>** **<u>For residents affected:</u>** *Nurse #1 and nurse #2 were immediately re-educated/counseled by RN on proper medication administration and expectations for resident's #72, #8 and #58 on 08-30-12. *Nurse #1 did obtain correct form of potassium for resident #72 and correct dose of calcium for resident #8 as reported to surveyor and those medications were delivered timely on 08-29-12. Nurse#1 reported errors for resident #72 and #8 to MD. No negative effect or change in condition resulted for residents involved and MD had no recommended changes in orders.	9-19-12

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F 332	Continued From page 5 1. Resident #72 had a doctor's order dated 01/09/12 for " Klor-con 10 meq (milliequivalent) 1 tablet by mouth everyday with food for Hypokalemia. Do not crush. " On 08/29/12 at 7:55 AM., Nurse #1 was observed during the medication pass. Nurse #1 was observed to prepare and to administer the medications for Resident #72. She crushed all the medications including the Klor-con and administered them with apple sauce. On 08/29/12 at 9:10 AM, Nurse #1 was interviewed. Nurse #1 acknowledged that she had crushed the Klor-con and stated that she would call the pharmacy if she could get the liquid form of Potassium 2. Resident #8 had a doctor's order dated 05/22/12 for Calcium Carbonate 600 mgs (milligram) 1 tablet by mouth twice a day for Osteoporosis. On 08/29/12 at 8:11 AM, Nurse #1 was observed during the medication pass. Nurse #1 was observed to prepare and to administer the medications including Calcium Carbonate extra strength 750 mgs. tablet. On 08/29/12 at 9:10 AM, Nurse #1 was interviewed. She acknowledged that she had administered Calcium Carbonate 750 mgs instead of 600 mgs as ordered. She stated that she would call the pharmacy to get the right dose of Calcium Carbonate. 3 a. Resident #58 had a doctor's order dated	F 332	*Nurse #2 did administer medication out of her normal sequence on resident #58 during medication observation. Meal carts were on floor to be delivered. Nurse #2 reported errors for resident #58 to MD. No negative effect or change in condition resulted for resident involved and MD had no recommended changed in orders. **For residents having potential to be affected:** *Nurse #1 and nurse #2 received formal training and counseling by DON on 09-05-12 on Medication administration and expectations. *Mandatory in-service for all nurses (including weekend and prn (pro re nata) or "as needed" nurses) was conducted Sept 19th at 7:30am and 2pm by pharmacy nurse consultant to review proper med pass administration. Any prn nurse failing to attend in-service will be mandated to contact DON prior to working next shift to arrange education. **Systemic changes/Monitoring solution:** *Nurse #1 and nurse #2 will be followed every month x 3 months by pharmacy nurse consultant or RN supervisor and performance issues addressed as indicated. Any further trends/concerns will be	

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F 332	Continued From page 6 08/25/11 for Os-cal 500+D 200 1 tablet by mouth twice a day for Osteoporosis. On 08/29/12 at 4:26 PM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the medications including Os-cal 500 mgs. On 08/29/12 at 5:05 PM, Nurse #2 was interviewed. She acknowledged that she had administered Os-cal 500 mgs instead of Os-cal 500 mgs with D 200 mgs as ordered. 3 b. Resident #58 had a doctor's order dated 10/30/11 for Essentials Mega Chelated Minerals 2 tablets by mouth twice a day with meals as supplement. On 08/29/12 at 4:26 PM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the resident's medications including the Essentials Mega Chelated Minerals. Resident #58 did not have her meal tray. The meal cart was observed to arrive on the hall at 5:00 PM and Resident #58 was not in her room. On 08/29/12 at 5:05 PM, Nurse #2 was interviewed. She stated that Resident #58 was visiting a resident on the other hall. She further stated that she always administers the resident's medications when the meal tray comes but she did not do it this time. 3 c. Resident #58 had a doctor's order dated 10/30/11 for Essentials Mega Antioxidant 2 tablets by mouth twice a day with meals as a	F 332	brought to QA committee and followed as indicated. *In addition, RN supervisors will conduct monthly med pass reviews on random nurses including all shifts including weekend staff to insure compliance to expectations. Concerns noted will be immediately addressed with employees involved. Any issues identified will be brought to QA committee and followed as indicated. *DON will conduct random audits over next qtr (at least one per month) to include at least 1 more observation of nurse#1 and nurse#2. Any concerns will be addressed immediately with staff involved. Trends or concerns will also be brought to QA committee for review and plan will be followed as indicated.	

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F 332	Continued From page 7 supplement. On 08/29/12 at 4:26 PM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the resident's medications including the Essentials Mega Antioxidant. Resident #58 did not have her meal tray. The meal cart was observed to arrive on the hall at 5:00 PM and Resident #58 was not in her room. On 08/29/12 at 5:05 PM, Nurse #2 was interviewed. She stated that Resident #58 was visiting a resident on the other hall. She further stated that she always administers the resident's medications when the meal tray comes but she did not do it this time.	F 332		
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334	**F334** **483.25(n) Influenza administration** **For residents affected:** *Resident #52, #58 received 2012-2013 influenza information sheets recommended by CDC (Centers for Disease Control) on 09-14-12. RN supervisors reviewed information with residents at that time to inform them of risks/potential side effects and benefits of immunizations. Both residents reported they have received information in past regarding immunizations and both gave consent for this season's influenza immunization administration scheduled to begin Oct 2012. Responsible representatives for both residents received phone calls from RN supervisors on 09-14-12 to review same information and to notify them of resident consent. Both family members agreed with consent for immunizations. *DON reviewed medical record of resident #52 and #58. Audit	9-19-12

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F 334	Continued From page 8 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal	F 334	proved documentation that the resident as well as responsible representative was provided education regarding the risks/potential side effects and benefits of influenza immunization. **For residents with potential to be affected:** *RN supervisors were educated on expectations of proper documentation of education provided regarding benefits and potential side effects prior to influenza immunization by DON on 09-14-12. *Mandatory in-service for all nurses (including weekend and prn "as needed" nurses) was conducted on September 19 to review influenza immunization requirements. Any prn (as needed) nurse failing to attend in-service is mandated to contact DON (Director of Nursing) to arrange education prior to next shift worked. **Systemic changes/Monitoring solution:** *RN supervisors will provide documentation in resident medical record (under "Admission" tab) of education provided regarding benefits and potential side effects upon obtaining consent and prior to administration for this year's 2012-2013 flu season.	

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F 334	Continued From page 9 Immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document in the resident's medical record that education regarding the risk and benefits of influenza immunization was provided to the resident or legal representative prior to vaccination on 2 (Residents # 58 & #52)of 5 sampled residents. The findings include: The facility's policy and procedure on Immunizations: Influenza (Flu) Vaccination of Residents, Staff and Volunteers with the revised date of 2009 was reviewed. The policy indicated that " informed consent in the form of a discussion regarding risks and benefits of vaccination will occur prior to vaccination. " 1. Resident #58 was admitted to the facility on 05/30/10. Review of the immunization record revealed that Resident #58 had received the influenza vaccine on 09/22/11. There was no evidence in the record that Resident #58 or her legal representative was provided education regarding risks and benefits of the vaccine prior to vaccination. On 08/30/12 at 11:05 AM, administrative staff #1 was interviewed. She stated that she could not find any documentation that education was	F 334	*DON will review all documentation by RN staff prior to this season's Influenza administration. *Any concerns noted in documentation of risks and benefits of immunizations will be addressed immediately with staff involved and issue brought forth to QA committee meeting and followed as indicated.	

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F 334	Continued From page 10 provided to Resident #58 or her legal representative prior to vaccination. 2. Resident #52 was admitted to the facility on 12/02/09. Review of the immunization record revealed that Resident #52 had received the influenza vaccine on 09/22/11. There was no evidence in the record that Resident #52 or her legal representative was provided education regarding risks and benefits of the vaccine prior to vaccination. On 08/30/12 at 11:05 AM, administrative staff #1 was interviewed. She stated that she could not find any documentation that education was provided to Resident #52 or her legal representative prior to vaccination.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356	**F 356** **483.30(e) Nursing services-posted nurse staff information** **For residents affected/residents with potential to be affected:** *Staffing coordinator immediately amended form used for posting staffing hours on 08-29-12. The form includes actual hours worked for RN, LPN, and C.N.A.s. The new form was posted 08-29-12 in prominent area at 300/400nurses station. *As of 09-14-12, the new staffing form was also prominently posted at nursing station 2 (500/600hall) so posting would be more visible for all to review. **Systemic changes/monitoring solution:**	9-14-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING ______ B. WING ______	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL HAVEN VILLAGE	155 BLAKE BLVD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 11 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to post daily staffing in a prominent location, with accurate information. The findings include: On 8/27/12 at 6:15 pm, during the initial tour of the facility, a bulletin board located across from the 300/400 halls nursing station and next to the activity room, contained a daily staffing for 8/27/12. Registered Nurses (RN) and Licensed Practical Nurses (LPN) were combined, instead of being listed separately. There were no actual hours worked for any of the disciplines, during any of the shifts. On 8/28/12 at 10:10 am and 8/29/12 at 1:30 pm, the daily staffing was completed in the same fashion with the RN and LPN's staff combined and not listing the actual hours of any of the nursing staff. At each nurse's station, a form that listed the names of nurse aides, LPN's and RN's	F 356	*RN supervisors will check posting of hours randomly at least 3xwk through September, then at least 2xwk through October, then at least 1x week for November to insure compliance to regulations. Any concerns noted will be forwarded to QA committee and followed as indicated. *DON will conduct random weekly audits for next qtr (quarter). Any concerns or trends noted will be addressed with Staffing Coordinator immediately and brought to QA committee for plan development as indicated.	

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F 356	Continued From page 12 as well as the resident census was listed, but it did not contain actual hours worked and/or remove the names of nurses, not performing direct care. Administrative Staff #3 was interviewed on 8/29/12 at 1:40 pm. She stated that for the last two years, she had been completing the daily staff posting and on the weekends, she had a shift supervisor update the form. Normally, she stated, she listed the unit supervisor under RN even though for the most part, they were not performing direct care with residents. She also did not know that she couldn't combine the RN and LPN staff on the posting or that she was required to list the actual hours worked, per discipline, per shift. She indicated that she would review the regulation and amend the form so that it would contain the right information. On 8/29/12 at 3:00 pm, the Administrative Staff #3 had successfully revised the daily staff form. The Administrator was notified on 8/30/12 at 1:45 pm that the daily posting was not in a prominent location and shared that the posting would be more visible for all to review.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F371** **<u>483.35(I) Food procure, store/prepare/serve-sanitary</u>** **<u>For residents affected/residents having potential to be affected:</u>** *Review of all refrigerated products conducted 08-30-12 by charge nurses, with follow up by RN supervisors that same afternoon. Outdated dairy drinks along with health shakes that were not dated were discarded. No other expired products or issues noted. *Review of all refrigerators/freezers conducted by DON evening of 08-30-12. No	9-20-12

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F 371	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and product label, the facility failed to: (1) remove outdated thickened dairy drink and (2) date health shakes when thawed in two (Unit 1 and Unit 2) of two nourishment refrigerators. The findings included: 1a. Observation on 8/30/12 at 8:54 AM of the Unit 1 refrigerator revealed 6 cartons of thickened dairy drink with a use by date on 8/27/12. During an interview on 8/30/12 at 8:54 AM, Administrative Staff #1 indicated that the night shift nursing staff checked the refrigerator and re-ordered items as needed. Administrative Staff #1 stated that the staff should remove outdated items for return to the dietary department. During an interview on 8/30/12 at 2:11 PM, the Dietary Manager indicated that dietary staff should remove any expired items when restocking the refrigerator. During an interview on 8/31/12 at 10:50 AM, the Dietician indicated that the facility did not have a policy on removing expired product from the refrigerators. 1b. Observation on 8/30/12 at 9:08 AM of the Unit 2 refrigerator revealed 1 carton of thickened dairy drink with a use by date on 8/27/12. During an interview on 8/30/12 at 8:54 AM,	F 371	issues noted. Items labeled as required and in date. **Systemic changes/monitoring solution:** *Night shift LPNs to check products in refrigerator q HS and discard any products soon to expire. Third shift check off form amended and initiated 09-06-12 to reflect intervention. *RNs to check refrigerators 3x week through September, 2xweek through October, and weekly through November to insure compliance to expectations of properly labeling health shakes, discarding expiring products starting 09-06-12. *DON to conduct random audits weekly through next quarter starting 09-06-12. Any issues noted will be brought to QA committee meeting and followed as indicated. *Dietary staff will pull mighty health shakes from freezer and label carton with "use by" date prior to delivery to nursing units. *Dietary staff will check all refrigerators a minimum of 2x week for any expiring products, proper storage and intervene as indicated by 09-19-12. A quality assurance form was created 09-14-12 to track and document intervention. Any issues noted will be brought to Dietary manager.	

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F 371	Continued From page 14 Administrative Staff #1 indicated that the night shift nursing staff checked the refrigerator and re-ordered items as needed. Administrative Staff #1 stated that the staff should remove outdated items for return to the dietary department. During an interview on 8/30/12 at 2:11 PM, the Dietary Manager indicated that dietary staff should remove any expired items when restocking the refrigerator. During an interview on 8/31/12 at 10:50 AM, the Dietician indicated that the facility did not have a policy on removing expired product from the refrigerators. 2a. Observation on 8/30/12 at 8:54 AM of the Unit 1 refrigerator revealed 7 cartons of a thawed, nutritional shake product. Printed on each carton was, "use within 14 days after thawing." During an interview on 8/30/12 at 8:54 AM, Administrative Staff #1 indicated that dietary delivered frozen shakes to the nursing unit and placed them in the freezer compartment of the nourishment refrigerator. She said on a daily basis nursing staff removed only the number of shakes needed for the day and put them in the refrigerator to thaw. Administrative Staff #1 stated that the shakes would not be left in the refrigerator for 14 days but acknowledged there was no way to ascertain the date the shake had been thawed. During an interview on 8/31/12 at 10:50 AM, the Dietician said she believed the shakes were used long before 14 days after thawing, but indicated that the shakes probably needed to be dated by	F 371	*Education of above dietary procedure changes is ongoing and to be completed on September 18, 2012. *Dietary manager will check all refrigerators at least weekly and conduct random audits of check off sheets by dietary staff by 09-19-12. A quality assurance form was created 09-14-12 to document intervention. Any issues noted will be forwarded to QA committee and followed as indicated.	

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F 371	Continued From page 15 the nursing staff when removed from the freezer. 2b. Observation on 8/30/12 at 9:08 AM of the Unit 2 refrigerator revealed 13 cartons of nutritional shake product. Five (5) cartons were thawed, the remaining 8 cartons were partially thawed. Printed on each carton was, "use within 14 days after thawing." During an interview on 8/30/12 at 9:08 AM, Nurse #1 stated that the 11-7 shift nurse moved the shakes from the freezer into the refrigerator so they would be thawed when needed during the day. Nurse #1 indicated that she could not be certain how long the cartons had been in the refrigerator. During an interview on 8/31/12 at 10:50 AM, the Dietician said she believed the shakes were used long before 14 days after thawing, but indicated that the shakes probably needed to be dated by the nursing staff when removed from the freezer.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	**F431** **483.60(b),(d),(e)Storage drugs** **For residents affected:** *Nurse #1 immediately discarded Novolog insulin and ordered new supply which was delivered timely the same day (08-30-12).Resident's personal home medication (Glucosamine) was returned on 08-30-12 with recommendation to discard. New supply of Glucosamine ordered and delivered timely the same day 08-30-12. **For residents with potential to be affected:** *Evaluation of both medication carts in facility was conducted by	9-19-12

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F 431	Continued From page 16 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to discard expired medications from one (500/600 medication cart) of two medication carts. The findings include: On 08/30/12 at 11:46 AM, the medication cart on the 500/600 hall was observed. A full bottle of Glucosamine with expiration date of 12/10 was observed. There was also a vial of Novolog with an open date of 07/28/12. On 08/30/12 at 11:59 AM, Nurse #1 was interviewed. She stated that insulin is good for 28 days after opening. She acknowledged that the	F 431	RN (Registered Nurse) staff on 08-30-12. No other expired medications were identified. No other issues noted. *Nurse on duty 08-30-12 educated on medication storage parameters by RN Clinical Supervisor on 08-30-12. Formal counseling conducted with nurse by DON (Director of Nursing) on 09-05-12. Storage parameter reference guide posted at nurses stations for review. **<u>Systemic changes/monitoring solution:</u>** *Night shift LPNs (Licensed Practical Nurses) to check for expired medications/proper medication storage in cart and medication room every night. Education provided on medication storage regulations 483.60 (b),(d),(e) and minimum storage parameters reviewed with night shift nurses 09-05-12 by Director of Nursing and again reviewed at mandatory in-service on 09-19-12 by Pharmacy Consultant. *Third shift check off form amended and initiated 09-06-12 to reflect intervention. *Mandatory in-service for all nurses (including weekend, and prn "as needed" nurses) on Medication Storage Parameters, conducted by pharmacy nurse consultant on September 19th at	

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F 431	Continued From page 17 Novolog was expired on 08/25/12 and should have been discarded. She further stated that a resident who was just admitted had brought the Glucosamine from home. She indicated that nurses were responsible for checking the expiration dates of the medications but had missed it. On 08/30/12 at 12:10 PM, administrative staff #2 was interviewed. She stated that insulin is good for 28 days after opening.	F 431	7:30 am and 2:00pm. Any prn "as needed nurse" that failed to attend in-service is mandated to contact Director of Nursing to arrange education prior to next shift worked. *RN's to check medication carts 3xweek through September, 2xweek through October, and weekly through November to insure compliance to expectations of Long Term Care guidelines of medication storage by 09-06-12. *Pharmacy nurse consultant will complete monthly checks of medication carts and medication rooms. Consultant will share information in exit conference with Director of Nursing after each visit. *Don will conduct random audits (a minimum of once a month) through next quarter and review all checks completed by facility and pharmacy RNs. Any issues noted will be immediately addressed with staff responsible. *Any issues noted will be forwarded to QA committee and followed as indicated.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345518	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2012

NAME OF PROVIDER OR SUPPLIER: QUAIL HAVEN VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 155 BLAKE BLVD, PINEHURST, NC 28374

OCT 30 2012

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This facility is Type V unprotected construction, and is equipped with an automatic sprinkler system.	K 000		
K 045 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 10/11/2012 following exit discharge illumination was observed as noncompliant: The specific findings include the following: No exit discharge lighting on the emergency power system the entire way to the public way from the "Living Room" exit.	K 045	K 045 – A certified electric contractor will install two 8 foot pole lights and six 8 inch high low lights to illuminate the entire walkway from the IL living room to the public way. This lighting will be on the emergency generator for back-up power. There were no other emergency lighting issues. The Maintenance Director will review with the campus QA Committee the actions taken at the next quarterly QA meeting.	11/20/12
K 056 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 10/25/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 056	Continued From page 1 for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 10/11/2012 the following Life Safety item was observed as noncompliant, specific findings include: The wash bay overhang just outside the service hall is not covered by the buildings automatic sprinkler. CFR#: 42 CFR 483.70 (a)	K 056	K056 – A certified sprinkler service contractor will install an additional sprinkler head in the wash bay outside of the service hall. This sprinkler head will cover the wash bay area in case of a an incident. There were no other sprinkler head issues. The Maintenance Director will review with the campus QA Committee the actions taken at the next quarterly QA meeting.	11/20/12